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ABSTRACT

The paper examines ways to help learning disabled (LD) adolescents adjust to the fact that they have learning disabilities. Underlying assumptions, such as the belief that learning disabilties are lifelong and affect social and psychological aspects, are reviewed. The importance of blending attitude and techniques in working with LD adolescents is stressed. The paper reviews an unsuccessful approach that emphasized intellectual knowledge of LD without the attitudinal component. The importance of assuming that learning disabilities are involved in behavior until proven otherwise and of understanding that performance on the same tasks may fluctuate from day to day are explained. A structured, behaviorally oriented process case management intervention approach is explained in which students are helped to view their behavior as alterable. (CL)

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[Integrating Learning Disabilities into the Life of Adolescents]

Robert Huestis
Cheryl Ryland

Paper presented at the Annual Conference of the Association for Children and Adults with Learning Disabilities 23rd, New York, NY, March 12-15, 1986

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OUTLINE OF PRESENTATION

I. Introduction
   A. Assumptions about L.D.
      1. Learning disabilities are life disabilities. They effect the social and psychological aspects of an adolescent's life.
      2. They are lifelong and don't go away.
      3. Learning disabilities can be compensated for and worked around to increase functioning, self-esteem and success.
      4. The identification of learning disabilities is only the start of the integration process and rarely, if ever, modifies the situation to any significant degree. In fact, over the last several years, we have found many adolescents and their families who can acknowledge the existence of learning disabilities but can't give any coherent description of how it really effects them functionally or emotionally.
      5. A different type of integration occurs at each different developmental level.

II. Therapeutic Attitudes
   A. L.D. is not black and white.
   B. Belief that L.D. exists and effects one's social and family life.
   C. An appreciation of how hard the struggle.

III. Videotape of L.D. adolescent performing academic task
   A. Diane - student
   B. Lou - teacher
   C. Exercise in folder

IV. Behaviorally Oriented Process Case Management
   A. Comparing case management with L.D. adolescents to traditional psychotherapy techniques.
   B. Structured
      1. Set times
      2. Shorter
      3. Time for review
      4. Here and now
   C. Process
      1. Role tracing
      2. Small behavioral alteration
      3. Empathic predictive disaster

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Presented ACLD March 1986

INTRODUCTION

Good morning - (comment about the time and materials)

What we would like to share with you today is some of our thoughts concerning the integration of learning disabilities with an adolescent. I think we all agree how important it is for anyone who had learning disabilities, at whatever age, to integrate this important facade of their life into an overall view of themselves. Our interest in this area grew out of earlier concerns that we had about the learning disabled adolescent and traditional psychotherapeutic interventions. It seems to us that this is a very much neglected area. To us, it stands to reason that there are enormous difficulties in applying standard psychotherapeutic techniques to learning disabled individuals with problems such as discrimination abilities, encoding, decoding, sequencing, and abstraction. Therefore, over the last 5 to 6 years in our treatment program, we have been looking for ways to modify these intervention techniques so that they correspond with the realities of dealing with a learning disabled individual.

Out of this concern, we developed a second concern which was, <u>what was the best way to help the adolescent integrate the fact that he had learning disabilities.</u>

Both Cheri and I work at Harding Hospital, a private regional psychiatric hospital in Columbus, Ohio. The adolescent program there encompasses outpatient therapy, adolescent day treatment and 40 inpatient adolescent beds. Granted we deal with more severely disturbed individuals who have a learning disability but we have found in other work that studying the severe end of the spectrum often is helpful to us in seeing the underlying principles and we have been able to apply

these underlying priciples across the board regardless of the actual severity of a situation.

From our work, we have acquired a set of truths or assumptions about learning disabilities and we would like to share them with you because we feel that it is important for you to know our position and what our assumptions are.

1. Learning disabilities are life disabilities. They effect the social and psychological aspects of an adolescents life.
2. They are lifelong and don't go away.
3. Learning disabilities can be compensated for and worked around to increase functioning, self-esteem and success.
4. The identification of learning disabilities is only the start of the integration process and rarely if ever, modifies the situation to any significant degree. In fact, over the last several years, we have found many adolescents and their families who can acknowledge the existance of learning disabilities but can't give any coherent description of how it really effects them functionally or emotionally.
5. Different types of integration occurs at each different developmental level.

   (Comment about in some respects this is a positive development)

Before we return to our main topic of helping the adolescent to integrate learning disabilities, a brief word about the families and parents of these adolescents. Even though we won't be talking about it today, we would like to emphasize our belief that effective treatment, (i.e. integration) does involve significant work with the parents and in our research, we have found that the essential psychological task that the parents must perform is one of mourning the real and imagined losses

that the parents feel when their child is identified as having learning disabilities.

Perhaps we ought to start with the word integrate. The dictionary definition is that it is to make whole, to bring all parts together, to unify. For us, this state of integration means the organization of organic, psychological and social traits and tendencies into a personality that is a harmonious whole. For this presentation, we will focus on our case management technique that we use with L.D. adolescent that we think is a significant part in the success of our program. What we most want to present today is our belief that the essential ingredients for a successful approach to the learning disabled adolescent is a blending of the proper attitude and techniques. This approach must fully appreciate where an adolescent is developmentally and emotionally and be based upon thorough understanding of learning disabilities and how these learning disabilities manifest themselves in social relationships. Cheri will next describe our understanding of how attitude plays a part in the therapeutic process with learning disabled adolescents.

In our work with the adolescent, we have had our share of failures. Perhaps the biggest has been what we call our didactic period. This, essentially, was a time spread over two years where we felt that, in order for an adolescent to better cope with his learning disabilities, he had to cognitively understand them, and we designed multiple programs to try to accomplish this. They included one-to-one instruction on learning disabilities in general, one-to-one instruction with adolescents about their specific learning disabilities and having learning disabled adolsecents meet together to discuss their L.D. and its effect upon them. This didn't work.

We then began to think along psychological developmental lines and did some integrating work ourselves. The adolsecents' major developmental task is separation and emancipation or, as we soemtimes put it, gracefully getting rid of their parents. In making this jump from family dependency to independence, it is easy to recognize the peer group dependency phase in the adolescent years. For normal adolescents, this is a period of uncertainty and insecurity, with part of those feelings being dealt with by a strong attachment to a peer group. As they struggle to find their own identity, a very common phenomenon is the temporary sense of security brought on by being like everyone else. Hence, the look alike dressing and the phenomenon of a fad taking hold in this age group and sweeping through it. Therefore, faced with insecurity and uncertainty as they try to find their identity, they very much want to view themselves as just like everyone else and, for the learning disabled adolescent, this becomes a period of time where it is extremely difficult to try and present didactic material to them that says very clearly, "you are different."

Our next step in gaining an appreciation of how important the attitude of the person working with the learning disabled child was when we started to be involved in reaching out, spreading the message within our hospital, both to the teachers and the other professionals across many disciplines. Essentially, what happened inside our institution mirrored very well society as a whole in that it was relatively easy to get professionals to intellectually understand learning disabilities and not much harder to get them to see how those disabilities played a part in a student's difficulty at school. We have had much less success getting professionals to acknowledge and understand and integrate how these same learning disabilities play a very active part in a family and social dysfunction.

So, where do we go from here? L.D. adolescents can't be educated directly and intellectual knowledge of L.D. does not sufficiently prepare a professional for work with L.D. adolescents. We believed then that cognitive knowledge and technique were necessary, but not sufficient. The missing piece was attitude. When we first thought about and wrote about our case management technique, we did not include the importance of attitude.

In recent years, we have tried to find ways to influence others in the development of the proper attitude. And we would like to try to do that with you today.

One important necessary attitude is the understanding that the expression of L.D. is not black or white. Learning disabled adolescents have peak functioning days when all cylinders are firing right, environmental conditions and psychological well-being are conducive, the learning disabled adolescent can function, cognitively, very well.

One cannot take these "peak" days as evidence and proof of the absence of L.D. and conclude the adolescent can "do it if he tries." This was again brought home to us as we videotaped five different L.D. adolescents performing a variety of exercises for us to prepare for this workshop. Several hours of tape are useless for an L.D. workshop because the adolescents performed consistently at their "peak" and there is nothing to show. These same adolescents "failed" similar exercises in the classroom or in the therapeutic milieu the previous day or the next day, after taping. I often thought, gosh, I wish I had that on tape to contrast with their performance that I did have on tape. If I were a novice and really didn't believe in L.D., watching the tapes would reinforce an attitude that he can "do it if he tries."

A second attitude, then, is a true belief that learning disabilities exist and that they effect not only academic life, but all areas of life. This attitude drastically changes our therapeutic interactions with learning disabled adolescents who are being treated for mental health problems. We assume that learning disabilities are involved in behavior until proven different. For example, if a patient is late or misses a therapy session, this is normally a sign of resistance and the patient is confronted under this assumption. With a learning disabled adolescent, missed appointments could be related to cognitive problems. David missed his first outpatient appointment with Bob following discharge from the hospital. When Bob called to inquire, he learned that the patient missed the appointment because he missed the exit off the outerbelt, could not compensate and drive the entire circumference of the outerbelt twice before he could figure out how to get back home. Without the right assumption, one misses an opportunity to empathically relate to this adolescent.

The last attitude I'm going to talk about comes from an intuitive, innate orientation to how difficult the struggle for an L.D. adolescent. David missed his exit, anyone can do that, but David had no workable strategy for compensating for his mistakes. Let me tell you another story related to me by a father who was willing to acknowledge his son had learning disabilities, but until this incident, he could not fully appreciate how hard the struggle. This father set the expectation that it was time for his 18 year old son, Alan, to get a full time job, despite his insecurities. Alan arranged an interview with a grocery chain for a bagger job. To get to the interview, he must travel from his house, downtown, and transfer to another bus to get to the grocery store. Father explains how to get a transfer and what bus to take from downtown, but he believes his son won't go so, on the day of the interview, the father follows his son and parks across the street, downtown, to observe. He watches his son get off the bus, transfer ticket in hand and walk to a corner to await his transfer bus. The bus comes, but Alan is on the wrong corner and misses his bus. The father can observe the patient's bewilderment, frustration, disappointment and inability to compensate or problem solve; empathy for how hard the struggle.

In summary, one must learn the proper attitude if one is going to be successful with L.D. adolescents. Just as a standard psychotherapist is trained to think and intervene therapeutically with regard to psychodynamic issues, one can also be trained to think therapeutically with regard to learning disabilities.

I now want to introduce you to the 15 minute videotape of Diane. In your folder, you have a copy of the exercise Diane performs on tape. Please take a minute to look at exercise one.

The video is of Diane and her regular English teacher at our school. Diane is 18 years old and has an average I.Q. She was identified as L.D. in the second grade and has received L.D. services in the public schools since that time. Her particular disabilities are: 1) cognitive impulsivity; 2) difficulty with abstraction and 3) a focus on details missing the big picture.

What we want you to attend to in the tape is:

1. The teacher's attitude and obvious relationship with this patient.
2. How hard the struggle - This task is relatively simple, yet she struggles considerably.
3. How would you predict from what you know about her disabilities and what you observe on tape what difficulties this patient might encounter in social relationships.

Now Bob will describe one of the techniques we use to help L.D. adolescents.

We call our intervention technique structured behaviorally oriented process case management. We have tried but we can't come up with a simplier name. Let me artificially break down the method into its component parts hopefully without destroying Gestalt.

STRUCTURED:

This term refers to the fact that we have scheduled meetings at set times each week for each individual adolescent with learning disabilities that are shorter and more frequent than we have with other adolescents in the program. These case management sessions have very specific characteristics. They are shorter because most learning disabilities interfere with the ability to attend to the task at hand. For example, the learning disabilities of auditory discrimination, auditory sequencing, encoding, decoding and abstraction all interfere with staying tuned in to a verbal therapy session. The resultant bordeom or frustration that occurs in these situations increase geometrically the longer the learning disabled adolescent is in such a situation.

Usually, we look at only one behavioral episode or segment at a time because again we found that most specific learning disabilities interfere with the ability to look at more than one thing at a time. For example, a child with a sequencing problem is going to have great difficulty dealing with an approach that is trying to help him link up verbally, episodes of misconduct that occurred last week, yesterday or the day before yesterday. In contrast to dealing with one segment at a time, most standard psychotherapy sessions involve actively trying to link up and simultaneously talk about similarities and differences between behavioral segments occuring in the past, present and future.

Likewise, our management sessions are individual sessions because we have found the processing a behavioral episode in a group setting is very difficult because once again the learning disabled adolescent is ill-equiped to deal with the constantly changing discriminations, sequencing and abstracting abilities needed.

These individual case management sessions are scheduled and unscheduled because we have found that both play a part in the treatment program. They are scheduled because:

1. We have found that the L.D. adolescent, if he knows that there is a setting for review, can better terminate from one behavioral segment without carrying it over to the next one.
2. It's very valuable to the impulsive learning disabled youngster to have some concrete experience in compartmentalization and segmentation of his thinking and feelings, i.e., part of maturing is learning to hold onto a problem until you are in the proper setting.
3. Having them regularly scheduled also means that the sessions are not always crisis oriented, therefore behavioral segments that are neutral or positive can also be examined.

On the other hand, we have found that we have to be flexible and willing to have impromptu meetings because these meetings with their immediacy are the ones that have an <u>affective or emotional component</u> to them and thus, if something is worked out, the emotional component is being integrated at the same time. Sterile review tends to provide sterile results.

Lastly, within the individual session, we try to create an expectation of structure. The framework that we try to provide is that it is the responsibility of the adolescent to bring a behavioral segment to the session; that there will be a general discussion or airing of the behavioral segment and lastly, a concrete recorded plan for change will be given to the adolescent. This could be written down on a sheet of paper or recorded on a tape depending on the strength and weakness of the adolescent.

BEHAVIORALLY ORIENTED:

In this term, we refer to our use of behavioral segments to initiate and focus on difficulties. At the beginning of treatment, we focus exclusively on those segments that occur in our treatment setting. We do not try to reconstruct the past and specific past history taking is held to a minimum. This departs from standard psychotherapy intervention where the past is much prized as an integral part of making links between the past and present. Therefore, at the beginning we don't try to process last night's fight with the parents or last year's fight with the teachers or fellow students. Instead, we look at some behavioral episode that has occurred in our program. Behaviorally oriented also refers to our trying to the best of our ability to avoid global abstract interventions such as "how did you feel about that?" and "what does that mean?" Incidentally, we have found that this insistence early on about behavioral segments, that have occurred in our treatment program, is very helpful in reinforcing the idea that no matter how others have reacted to them, the adolescent has some individual responsibility for making his own personal changes if he is to have a more productive functional life.

PROCESS CASE MANAGEMENT:

This term refers to our particular technique by which we try to bring a general meaning or conceptualization to the adolescent about his difficulties, insight if you will. We do this by reviewing behavioral segments in a different way within the case management session. Essentially, we take a behavioral segment and then branch out from that segment to examine other options that the adolescent has or feels that he has or should have or options that he isn't aware that we provide for him. It is in the process of looking at a behavioral segment and these various options that we help learning disabled adolescents develop insight into their behavior or to use another term, help them develop an observing ego. I want to point out again how this differs from standard individual psychotherapy where often the process of abstraction to get the insight comes about by linking behavioral episodes in time. In standard psychotherapy, there are many comments such as "I think this looks like the same difficulty you had last week," or "have you noticed how every time you are in that situation, certain difficulties arise?" In traditional therapy, there is a bias that when an individual has these links, it produces insight and he will change his behavior with minimal direction from the therapist. In our branching out option process oriented technique, we do not make this assumption and in fact, actively guard against it. Learning disabled kids can change but they have to be prepared to change. Our bias is that we need to be active but constantly guard against taking over for the adolescent. Some specific maneuvres that we use in order to bring forth various options to an adolescent are as follows:

1. Role Tracing. We especially emphasize that the adolescent play both sides of the conflict and do this in a step-by-step fashion,

having them follow the consequences of a particular action. For example, an adolescent would walk out of the Harding School without permission and would meet with one of us in case management. We would have him reconstruct the immediate behavior segment and then follow it step-by-step to the end. In this example, this adolescent would then start with the behavior of walking out of class and proceed to tell us what happened in sequence until he met with us. We would then retrace this episode using a different behavior such as putting your head down on the dest and going to sleep and then asking what would happen next, etc. We would also ask him to trace the role of the teacher. Eventually as we talk about different response patterns, we are presenting indirectly different options to the adolsecent and we are laying the ground work or foundation for him to develop (through repeated processing of this kind) an observing ego or "insight."

2. Small behavorial alterations. By this, we mean focusing on a very small piece of behavior if we are going to suggest a change. We have learned that it has to be specific and that we have to have subsequent feedback about this change. I want to emphasize that most learning disabled kids do not think of alternative behavior by themselves. Let me give you an example: If we have a patient who is covering up his insecurity with grandiose expression such as "I am the best," telling him to "tone it down" would not be enough anymore than giving him an interpretation about his grandiosity and linking it to his insecurity. For example, "it seems that in every new situation where you feel insecure, you have a tendency to brag yourself up. Maybe you should try something different." Instead, we told him to say

"I like" instead of "I'm best." Again we take specific behavioral segments, ask adolescents to change very small specific behaviors and go over the results with them. The learning disabled adolescent begins to see different options and to draw different conclusions or insights.

3. Empathic predictive disaster. Adolescents like to make their own plans. In this technique, we predict in a non-critical manner to the learning disabled adolescent that he will experience difficulty in an upcoming activity using his plans. We allow the adolescent to be in a situation that will be difficult for him and tell him that before hand. If we attempted to do this afterward, it would increase the anxiety and defensiveness, make it more difficult to talk about and arouse "I told you so" resistences. When we empathically predict ahead of time, the adolescent begins to view the worker in a different more positive light and is much more receptive to looking at other options linked to a behavioral episode.

In summary, we take many behavioral episodes, process them in this very specific way of branching out from the behavioral segment, and look at various options that both the adolescent and treater produce. A gradual awareness develops that things can be understood socially and emotionally and just as importantly, the adolescent begins to become aware that they can be different. This of course, helps increase their motivation to deal with the social, emotional and psychological sequelae of their learning disability. Lastly, I want to emphasize at this point that none of the techniques that I have mentioned above involve discussing the specific learning disability with the adolescent but it does very much require that the helper thoroughly understand the adolescent learning

disabilities and to have a feel for how that disability will manifest itself in social and psychological situations.

During the adolescent years, we believe a direct didactic approach does not work. Instead, we approach from the side and focus on how his life is effected and present him/her with options that not only have their own therapeutic value but also help him begin to interprete what disabilities he has and what will help.